The Audit Landscape Including Medicaid RACs: Is Your Organization Prepared?

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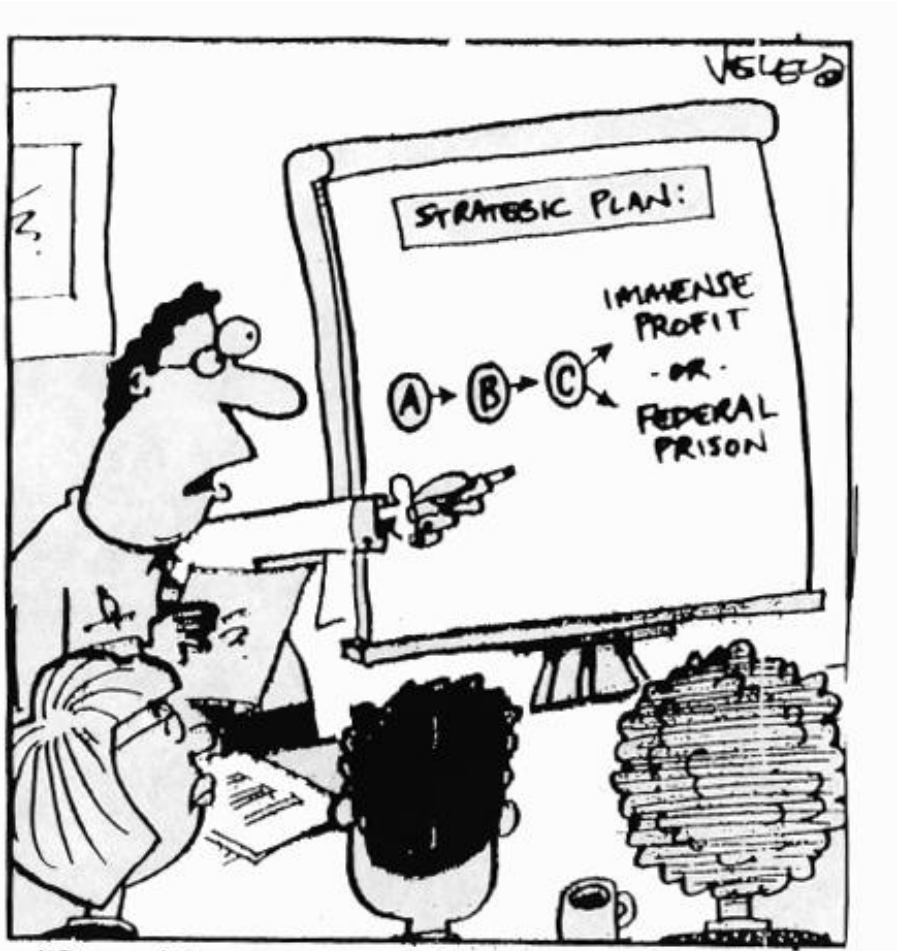
Compliance/Future of Audits



"Stay with me now, people, because in step C, things get a bit delicate."

The Future of Audits

- Medicare
  - Recovery Audit Contractors (RACs)
  - Program Safeguard Contractors (PSCs)/ Zone Program Integrity Contractors (ZPICs)
- Medicaid
  - Medicaid Integrity Contractors (MICs)
  - RACs
- Private Payors
  - Third party recovery vendors
  - Internal audit and fraud and abuse units
- NY Office of Medicaid Inspector General (OMIG)
  - Audits of Office for People with Developmental Disabilities (OPWDD) facilities and providers

RAC Reality

- Recovery Audit Contractors- What are they?
- New under Health Care Reform-The Medicaid RACs- But first understanding the Medicare RAC program (The Model)----
  - States required to establish programs in which they would contract with 1 or more Medicaid RACs by December 31, 2010
  - Medicaid RACs tasked with reviewing Medicaid claims submitted by providers of services for which payment is made under 1902(a) of the SSA or a waiver of the State plan
  - Identification of underpayments
  - Identification and collection of overpayments
  - April 2011 implementation date extended- future rule making later this year to provide dates

Medicare:
RAC Demonstration Project

- MMA 2003- launched RAC Demonstration Project
- Purpose to evaluate the use of RACs in identifying Medicare underpayments and overpayments and recouping overpayments
- 2005-2008
- Connolly Consulting performed reviews for NY providers-

Medicare:
RACs

- RACs are private companies contracted by CMS, tasked with ***identifying and correcting Medicare improper payments*** (overpayments and underpayments).
- RACs are compensated on a ***contingency fee*** basis based on the principal amount collected from and/or returned to the provider or supplier.
- Region A – 12.45% contingency fee- (9 to 12.5%)

Medicare:
RACs

- Although the RACs are responsible for correcting *all* types of improper payments, during the demonstration program:
  - RACs identified and collected $992.7 million in **overpayments** (96%)
  - RACs ordered repayment of $37.8 million in **underpayments** (4%)
  - Part B, Part A, Part C and Medicaid

Medicare
The History: The RAC Demonstration

- ***Results*** – The Demonstration Program proved highly "cost effective" for CMS
  - RACs identified more than $1.03 billion in improper payments
  - CMS estimates that the RAC demonstration program cost approximately 20¢ for each dollar returned to the Medicare Trust Funds
    - *Data published prior to the completion of the Medicare appeals process for many claims.*
    - *Low percentage of claims actually appealed*

Medicare:
Making RACs Permanent

- Section 302 of the Tax Relief and Health Care Act of 2006
  - Made the RAC program permanent and required nationwide expansion by 2010
  - Medicare RAC program now operational nationwide

RAC Reviews

- Targeted Review – RACs use proprietary data techniques to determine claims likely to be overpayments
  - Audits are *not* random
- 2 Types of Reviews for Improper Payment
  - ***Automated Review*** – A review of claims data without a review of records
  - ***Complex Review*** – A review of medical or other records

RACs: Identifying Improper Payments

- RACs are permitted to attempt to identify improper payments resulting from
  - Incorrect payments;
  - Non-covered services (including services that are not reasonable and necessary);
  - Incorrectly Coded Services (including DRG miscoding); and
  - Duplicate services

RAC Complex Review

- In a complex review, the RAC will request records from the provider for review
  - Record request limits published on CMS RAC website: www.cms.hhs.gov/RAC
- Importance of timely response to claims

RAC Complex Review

- In conducting reviews, RACs are required to comply with NCDs, coverage provisions in Interpretive Manuals, LCDs, national and local coverage and coding articles.
  - RACs also are authorized to develop internal guidelines to use in reviewing claims.
- Generally speaking, a RAC must complete complex reviews within 60 days from receipt of the requested medical records.
- Following its review, the RAC will issue a letter to the provider setting forth the findings for each claim and notifying the provider of appeal rights.
  - Review results letter
  - Demand letter

RAC Audits – Key issues

- RAC reviewers have a 3-year maximum look-back- HOW WILL MEDICAID WORK?
- Registered nurses or therapists are required to make determinations regarding medical necessity, and certified coders are required to make coding determinations
- RACs are not entitled to keep their contingency fees if a denial is overturned on appeal- Proposed Medicaid RAC Rules consistent --

RAC Audits – Key issues

- Discussion Period- filing of appeal ends discussion period (not part of formal appeals process)
- Appeal Rights

Medicare:
RAC Vendors

- www.cms.hhs.gov/RAC
  - **Region A –** Northeast States
    - Diversified Collection Services, Inc., of Livermore, CA
    - www.dcsrac.com
    - Will Medicaid RACs have similar websites?
  - **Region B –** Midwestern States
    - CGI Technologies and Solutions, Inc. of Fairfax, VA
    - http://racb.cgi.com
  - **Region C –** Southeast States
    - Connolly Consulting Associates, Inc. of Wilton, CT
    - www.connollyhealthcare.com/RAC
  - **Region D –** Western States
    - HealthDataInsights, Inc. of Las Vegas, NV
    - http://racinfo.healthdatainsights.com

Medicaid:
RAC Timeline

- 3/23/2010 – Section 6411 of PPACA expanded RACs to Medicaid-
  - Medicaid RAC program administered by States and Medicare RAC program administered by CMS
- 10/1/2010 – CMS letter to State Medical Directors- providing guidance regarding Medicaid RACs
- 11/10/2010- 75 Fed. Reg. 69037- Proposed Rules on Medicaid RAC program
- 12/22/2010 – CMS received NY Medicaid State Plan Amendment (SPA)
- 3/8/2011 – NY SPA approved
- 2/1/2011 – CMS Bulletin – delaying full implementation (4/1/2011) until later in the year
- Final Rule
- Contingency Fee

Medicaid RACs

- Supplemental approach to Medicaid program integrity efforts already underway (e.g., MIP audits)
- Contingency fee can only be paid from amounts recovered- payments cannot exceed amounts recovered and cannot be based on amounts identified (appeal issues)
- No set rate- but generally cannot exceed highest Medicare RAC contingency fee

Medicaid RACs

- Whenever RACs have reasonable grounds to believe that fraud has occurred- must report to appropriate law enforcement officials
  - Only 2 referrals in Medicare Demonstration
- Like MIP- State has to return Federal share of overpayments regardless of whether State goes after recovery from provider---
- Appeals- must have appeals under this program- State can use existing administrative appeals infrastructure or can create a new one
- RAC contractor must agree to coordination of efforts with other agencies etc.
- Statistical sampling?
- Look back periods?
- Website requirements?
- Staffing and qualifications?

Medicare:
PSC/ZPIC Audits

- PSCs are ***responsible for performing benefit integrity functions***, including:
  - Fraud and abuse investigation and detection
  - Overpayment identification
  - Case resolution (*e.g.*, coordination of overpayment recovery; referral to law enforcement)

Medicare:
PSC/ZPIC Audits

- PSCs are authorized to:
  - Conduct prepayment reviews
  - Recommend suspensions of payment
  - Conduct post-payment audits and extrapolate the amounts of alleged overpayments identified
- Unlike RACs, PSCs are <u>not</u> compensated on a contingency-fee basis
- Statistics
- Data analysis driven—significant audit activity around the country

Medicare:
PSC/ZPIC Audits

- PSCs are transitioning to ZPICs to align with the Medicare Administrative Contractors (MACs), once that transition occurs.

Medicaid:
MIC Overview

Å The Deficit Reduction Act of 2005 added Section 1936 to the Social Security Act, which created the Medicaid Integrity Program (MIP) and required CMS to procure contractors to perform (4) functions:

1. ***Review*** provider actions
2. ***Audit*** claims
3. ***Identify*** overpayments
4. ***Educate*** providers and others with respect to program integrity and quality of care

*Development of internet-based Medicaid Integrity Manual to include additional granularity on MIP activities

Medicaid:
MIC Overview

- 3 Types of MICs
  - ***Review*** (R) – Analyze claims data to identify high-risk areas and potential vulnerabilities
  - ***Audit*** (A) – Conduct post-payment audits to identify overpayments
  - ***Education*** – Gather findings from Audit/Review MICs and identify areas for education

**** In NY, the Audit MIC is IPRO****

**** IPRO has initiated MIC audits in New York****

Medicaid:
MIC Overview

- Audit MICs are entities with which CMS has contracted to perform audits of Medicaid providers
- Unlike RACs, MICs are not compensated on a contingency fee basis
- ***Objectives of Audit MICs*** – to ensure that paid claims are:
  - For services provided and ***properly documented***;
  - For services billed using ***appropriate procedure codes***;
  - For ***covered services***; and
  - In ***accordance with Federal and State laws, regulations and policies***
- Data analysis driven
- State law appeals process

Medicaid:

Steps in the Provider Audit Process

Step 1 – Data Analysis

- The Medicaid Integrity Group (MIG) and Review MICs examine all paid claims using the Medicaid Statistical Information System (MSIS).
  - MIG identifies potential areas that are at high risk for overpayments or fraudulent claims that require additional review by Review MICs.
  - The Review MICs identify the specific providers on which the Audit MICs should focus their auditing efforts.
- Data driven approach intended to focus audits on those providers with “truly aberrant” billing practices.

Medicaid:

Steps in the Provider Audit Process

Step 2 – Vetting Potential Audits

- Prior to providing an Audit MIC with an audit assignment, CMS "vets" the providers identified for audit with:
  - State Medicaid agencies
  - State and Federal law enforcement agencies
  - Medicare contractors
- Entities listed above are provided a list of the potential audits generated by data analysis. If any stakeholder is performing an audit of the same provider for similar Medicaid issues, CMS may cancel or postpone the Audit MIC's audit of the provider.

Medicaid:

Steps in the Provider Audit Process

Step 3 – Audit MIC Receives Audit Assignment

- Upon completion of the vetting process, CMS forwards the audit assignments to the Audit MIC, and the Audit MIC immediately begins auditing.
- CMS' policy is that the audit period, also known as the "look back period"- September 29, 2010 Bulletin -5 years prior to start date of audit- no Federal law for time limit
  - 5 year time period begins on date of issuance of Notification letter to the provider.

Medicaid:

Steps in the Provider Audit Process

Step 4 – Audit MIC Schedules Entrance Conference

- Audit MIC's initial communication with the provider includes the following:
  - An audit notification letter, which identifies a contact person in the Audit MIC and gives the provider at least two (2) weeks' notice of the audit
  - Records request
    - If desk audit is to be performed – records must be mailed to the Audit MIC; or
    - If field audit is to be performed – records must be made available onsite to the Audit MIC

Medicaid:

Steps in the Provider Audit Process

Step 4 – Audit MIC Schedules Entrance Conference

- Audit MIC will coordinate with the provider to schedule an entrance conference to communicate relevant information regarding the audit, including its scope and objectives.
  - May be conducted in person or by phone

Medicaid:

Steps in the Provider Audit Process

Step 5 – Audit MIC Performs Audit

- Most audits are desk audits
- Providers are given timeframes to produce records; if an extension is requested, the Audit MIC will "seriously consider" this request
  - CMS policy 30 business days to produce.

Medicaid:

Steps in the Provider Audit Process

Step 6 – Exit Conference and Draft Audit Report

- Audit MIC will coordinate with the provider to schedule an exit conference to communicate preliminary audit findings and tentative conclusions.
  - May be conducted in person or by phone
  - The provider will have an opportunity to comment on the preliminary findings and provide additional information where appropriate
- If the Audit MIC concludes that there is a potential overpayment, the Audit MIC also prepares a draft report.

Medicaid:

Steps in the Provider Audit Process

Step 7 – Review of Draft Audit Report

- Draft audit report submitted to several agencies for review, comment and approval:
  - Report shared with CMS for approval
  - Report submitted to the State for review and comment
  - Report provided to the provider for review and comment
- Where appropriate, the draft is revised and then shared again with the State

Medicaid:

Steps in the Provider Audit Process

Step 8 – Draft Audit Report is Finalized

- Upon completion of the review of the draft audit report, audit findings may be adjusted based upon the information provided by the State and the provider.
  - Guidance from CMS states that, “The provider will be given credit for payments it is able to justify.”
- At this point, the audit report is finalized.

Medicaid:

Steps in the Provider Audit Process

Step 9 – CMS issues Final Audit Report

- CMS sends its final audit report to the State.
- Per 42 C.F.R. §§ 433.316 (a) & (e), sending the final audit report to the State serves as CMS' official notice to the State of the discovery and identification of an overpayment.
  - Under Federal law, the State must repay the Federal share of the overpayment to CMS within 60 calendar days, whether or not the State recovers, or seeks to recover, the overpayment from the provider.

Medicaid:
Steps in the Provider Audit Process

Step 10 – State Issues Final Audit Report to Provider and Begins Overpayment Recovery

- The State will issue the final audit report to the Provider.
- Each state follows its respective administrative process.
- The provider may exercise appeal rights are available under State law at this time.

Sample Issues in Audits

- Sample cases-DHHS-Office of Audit Services-Series of Medicaid audits involving improper payments for behavioral health services-Illinois, Indiana, Kansas, Washington
  - E.g., September 2006 Report: Found Illinois program overpaid community mental health service providers- **services not documented**; issues with services **not involving direct patient care** (billed for attempted phone calls; client transportation where transportation was the primary service); treatment plans not signed; services provided by those who lacked proper credentials; number of service units were not supported in the documentation, etc.

QUESTIONS?

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